MARKET CONDUCT EXAMINATION REPORT
AS OF DECEMBER 31, 2007

COLORADO CHOICE HEALTH PLANS
d.b.a. SAN LUIS VALLEY HMO
700 Main Street, Suite 100
Alamosa, Colorado 81101

NAIC Company Code
95774

EXAMINATION PERFORMED BY
STATE OF COLORADO
DEPARTMENT OF REGULATORY AGENCIES
DIVISION OF INSURANCE

CERTIFICATE OF COPY

I, **Marcy Morrison**, Commissioner of Insurance of the State of Colorado, do hereby certify that the attached is a true and correct copy of the Market Conduct Examination Report as of December 31, 2007 for **Colorado Choice Health Plan d.b.a. San Luis Valley HMO** now on file as a record of this office.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal of office at the City and County of Denver on this 4th day of December 2008.

Marcy Morrison
Commissioner of Insurance

Colorado Choice Health Plans
d.b.a. San Luis Valley HMO
700 Main Street, Suite 100
Alamosa, Colorado 81101

MARKET CONDUCT EXAMINATION REPORT as of December 31, 2007

Examination Performed by
Jeffory A. Olson, CIE, FLMI, AIRC, ALHC
Senior Market Conduct Examiner
Colorado Division of Insurance

September 8, 2008

The Honorable Marcy Morrison
Commissioner of Insurance
State of Colorado
1560 Broadway, Suite 850
Denver, Colorado 80202

Commissioner Morrison:

This limited market conduct examination of Colorado Choice Health Plans, d.b.a. San Luis Valley HMO, was conducted pursuant to §§ 10-1-201, 10-1-203, 10-1-204, and 10-16-416, C.R.S., which authorize the Commissioner of Insurance to examine health maintenance organizations. The Company's records were examined at the offices of the Division of Insurance (Division) at 1560 Broadway, Suite 850, Denver, Colorado, 80202. The market conduct examination covered the period from January 1, 2007, through December 31, 2007.

The results of the examination are respectfully submitted by the following market conduct examiner:

Jeffory A. Olson, CIE, FLMI, AIRC, ALHC

MARKET CONDUCT
EXAMINATION REPORT
OF
COLORADO CHOICE HEALTH PLANS d.b.a SAN LUIS VALLEY HMO

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COMPANY PROFILE

Colorado Choice Health Plans d.b.a. San Luis Valley HMO (SLVHMO or Company) was organized as a not-for-profit Colorado corporation on March 24, 1972, and operates as a Section 501(c)(4) corporation. SLVHMO began its operations on May 1, 1975 as a licensed health maintenance organization (HMO). The Company changed its corporate name in 2004 to Colorado Choice Health Plans, but uses the d.b.a. of San Luis Valley HMO for its operations.

SLVHMO does not have any subsidiaries or affiliated companies and is not a subsidiary of any other company. SLVHMO is entirely self-managed and does not receive any management services from any other entity.

SLVHMO is licensed to operate in seven counties in the State of Colorado. The counties served by the Company are: Alamosa, Conejos, Costilla, Fremont, Mineral, Rio Grande, and Saguache.

SLVHMO offers commercial products to small and large employer groups, and to direct pay individuals. The Company also offers a Medicare cost contract that provides health care for Medicare eligible individuals. In addition, the Company offers Third Party Administration (TPA) services to self-funded employer groups.

Service Area

The Company is licensed to provide services in Alamosa, Conejos, Costilla, Fremont, Mineral, Rio Grande, and Saguache counties in Colorado.

Enrollment As of 12-31-07:	Small Group	1,987
	Large Group	2,481
	Individual	55
	Total	4,523

Written Premium as of 12-31-07:	Small Group	$ 6,115,959
	Large Group	$ 8,585,746
	Individual	$ 180,704
	Total	$14,882,409

Market Share: (All Colorado HMO Business) 0.43%

Health Care Delivery:

SLVHMO contracts with independent physician associations, physician group practices, and independent physicians, as well as hospitals, mental health facilities and other ancillary providers to provide primary and specialty care. The Company pays for health care services through a combination of capitation, negotiated fee for service and per diem arrangements.

PURPOSE AND SCOPE

In accordance with Colorado insurance laws, §§ 10-1-201, 10-1-203, 10-1-204 and 10-16-416, C.R.S., which empower the Commissioner to require any company, entity, or new applicant to be examined, a state market conduct examiner reviewed certain business practices of SLVHMO. The information contained in this report, including all work products developed in producing it, are the sole property of the Division.

The purpose of this market conduct examination was to determine the Company's compliance with Colorado insurance laws related primarily to individual and small group coverage. Examination information contained in this report should serve only these purposes. The conclusions and findings of this examination are public record.

This market conduct examination was conducted in accordance with procedures developed by the Division, based on model procedures developed by the National Association of Insurance Commissioners (NAIC). The examiner relied primarily on records and materials maintained and/or submitted by the Company. The market conduct examination covered the period from January 1, 2007, through December 31, 2007.

The examination was limited to review of the following:

Operations and Management
Policy Forms
Claims
Utilization Review

The final examination report is a report written by exception. References to additional practices, procedures, or files that did not contain improprieties were omitted. Based on the review of these areas, comment forms were prepared for the Company identifying any concerns and/or discrepancies that were discovered. The comment forms include a section that permits the Company to submit a written response to the examiner's comments.

For the period under examination, the examiner included statutory citations and regulatory references related to small group and individual insurance laws as they pertained to health maintenance organizations. Examination findings may result in administrative action by the Division. The examiner may not have discovered all unacceptable or non-complying practices of the Company. Failure to identify specific Company practices does not constitute acceptance of such practices. This examination report should not be construed to either endorse or discredit any health maintenance organization.

An error tolerance level of plus or minus ten dollars ($10.00) was allowed in most cases where monetary values were involved. However, in cases where monetary values were generated by computer or system, a zero dollar ($0) tolerance level was applied in order to identify possible system errors.

EXAMINER'S METHODOLOGY

The examiner reviewed the Company's business practices to determine compliance with Colorado statutes and regulations as they pertain to health maintenance organizations. For this examination, special emphasis was given to the laws and regulations shown in Exhibit 1.

Exhibit 1

Statute or Regulation	Subject
Section 10-1-128, C.R.S.	Fraudulent insurance acts - immunity for furnishing information relating to suspected insurance fraud - legislative declaration.
Section 10-3-1104, C.R.S.	Unfair methods of competition and unfair or deceptive acts or practices.
Section 10-8-513, C.R.S.	Eligibility for coverage under the program.
Section 10-16-102, C.R.S.	Definitions.
Section 10-16-104, C.R.S.	Mandatory coverage provisions - definitions.
Section 10-16-104.3, C.R.S.	Dependent health coverage for persons under twenty-five years of age.
Section 10-16-105, C.R.S.	Small group sickness and accident insurance - guaranteed issue - mandated provisions for basic and standard health benefit plans – rules – benefit design advisory committee - repeal.
Section 10-16-106.5, C.R.S.	Prompt payment of claims – legislative declaration.
Section 10-16-108, C.R.S.	Conversion and continuation privileges.
Section 10-16-113, C.R.S.	Procedure for denial of benefits – rules.
Section 10-16-113.5, C.R.S.	Independent external review of benefit denials - legislative declaration - definitions.
Section 10-16-118, C.R.S.	Limitations on preexisting condition limitations.
Section 10-16-201, C.R.S.	Form and content of individual sickness and accident insurance policies.
Section 10-16-202, C.R.S.	Required provisions in individual sickness and accident policies.
Section 10-16-214, C.R.S.	Group sickness and accident insurance.
Section 10-16-407, C.R.S.	Information to enrollees.
Section 10-16-409, C.R.S.	Complaint system.
Section 10-16-413, C.R.S.	Prohibited practices.
Section 10-16-416, C.R.S.	Examination.
Section 10-16-421, C.R.S.	Statutory construction and relationship to other laws.
Section 10-16-423, C.R.S.	Confidentiality of health information.
Section 10-16-427, C.R.S.	Contractual relations.
Section 10-16-704, C.R.S.	Network adequacy – rules – legislative declaration - repeal.
Section 10-16-705, C.R.S.	Requirements for carriers and participating providers.
Insurance Regulation 1-1-7	Market Conduct Record Retention
Insurance Regulation 1-1-8	Penalties And Timelines Concerning Division Inquiries And Document Requests

Insurance Regulation 4.2.6	Concerning the Definition of the Term "Complications of Pregnancy" for Use in Accident and Health Insurance Contracts and Certificates
Insurance Regulation 4-2-8	Concerning Required Health Insurance Benefits for Home Health Services and Hospice Care
Insurance Regulation 4-2-11	Rate Filing and Annual Report Submissions Health Insurance
Insurance Regulation 4-2-13	Mammography Minimum Benefit Level
Insurance Regulation 4-2-16	Women's Access to Obstetricians and Gynecologists under Managed Care Plans
Insurance Regulation 4-2-17	Prompt Investigation of Health Plan Claims Involving Utilization Review
Insurance Regulation 4-2-18	Concerning the Method of Crediting and Certifying Creditable Coverage for Pre-Existing Conditions
Insurance Regulation 4-2-19	Concerning Individual Health Benefit Plans Issue to Self-employed Business Groups of One
Insurance Regulation 4-2-21	External Review of Benefit Denials of Health Coverage Plans
Insurance Regulation 4-6-5	Concerning Implementation of Basic and Standard Health Benefit Plans
Insurance Regulation 4-6-7	Concerning Premium Rate Setting for Small Group Plans
Insurance Regulation 4-6-8	Concerning Small Employer Health Plans
Insurance Regulation 4-6-9	Concerning Conversion Coverage
Insurance Regulation 4-7-1	Health Maintenance Organizations
Insurance Regulation 4-7-2	Concerning the Laws Regulating Health Maintenance Organization Benefit Contracts and Services in Colorado
Insurance Regulation 6-4-2	Standards for Safeguarding Customer Information

Audits and Examinations

The examiner reviewed the report of the most recent financial examination of the Company for the period ending December 31, 2005, performed by the Division's financial examination staff.

Policy Forms

The examiner reviewed the following policy forms:

- Basic and Standard Benefit Plans and Copayment Schedules 1/06;
- Small Group Medical and Hospital Service Agreement 12/05;
- Small Group Benefit Schedule 12/05;
- Direct Pay Medical and Hospital Service Agreement 12/04;
- Direct Pay Benefit Schedule Series 12/04;
- Group Application for Membership (No Date);

- Benefit Schedule for Employer Groups – Amendment (No Date); and
- Benefit Schedule for Employer Groups – Signature Sheet (No Date).

These forms were in use or available for use by the Company during the examination period, and were certified with the Division as being in compliance with all Colorado insurance laws.

Claims

Using ACL ™ software, the examiner selected random samples of 100 paid and fifty (50) denied claims from populations of 37,361 and 4,006 respectively, which were received from January 1, 2007, through December 31, 2007. These sample claims were reviewed to evaluate the Company's overall claims handling practices including accuracy of processing. In addition, the entire population of six (6) claims that were not paid, denied, or settled within forty-five (45) days, and two (2) claims that were not paid, denied or settled within ninety (90) days were reviewed to determine if they were adjudicated in compliance with Colorado's prompt payment of claims requirements.

Utilization Review

The examiner reviewed the Company's utilization management program including policies and procedures. The examiner selected a random sample of fifty (50) utilization review (UR) decision files from a population of 4,025 files. These sample files were reviewed for the Company's overall UR handling practices, including timeliness of completing the review and communication of the UR decisions to the appropriate persons.

In addition, the examiner reviewed the entire population of twenty (20) first level appeal files and two (2) voluntary second level appeal files to determine if they were handled in compliance with Colorado insurance laws.

EXAMINATION REPORT SUMMARY

The examination resulted in a total of eleven (11) findings in which the Company did not appear to be in compliance with Colorado insurance laws. The following is a summary of the examiner's findings.

Policy Forms: Eight (8) areas of concern were identified during the review of the Company's policy forms.

Issue E1: Failure, in some instances, to qualify dependent eligibility in accordance with the requirements of Colorado insurance law. *(This was prior issue E1 in the findings of the market conduct examination report dated September 6, 2002.)*

Issue E2: Failure, in some instances, to limit Members' liability to the stated copayments. *(This was prior issue E2 in the findings of the market conduct examination report dated September 6, 2002.)*

Issue E3: Failure of the Company's individual health plan forms, in some instances, to provide coverage for complications of pregnancy and childbirth in the same manner as any other sickness, injury, disease or condition is covered.

Issue E4: Failure, in some instances, to provide dependent coverage beyond thirty-one (31) days if notification of the dependent's birth or placement for adoption is not received within thirty-one (31) days.

Issue E5: Failure, in some instances, to reflect coverage for transplants in accordance with Colorado insurance law.

Issue E6: Failure of the Company's forms, in some instances, to include coverage for basic health care services.

Issue E7: Failure of the Company's Basic and Standard health benefit plan forms to provide mandated coverage for dental care needed as a result of an accident.

Issue E8: Failure, in some instances, to provide continuation coverage if an individual is eligible for Medicare or Medicaid.

Claims: Two (2) areas of concern were identified during the review of the Company's claims practices.

Issue J1: Failure, in some instances, to allow the required thirty (30) calendar days for necessary additional information to be received before denying an unclean claim.

Issue J2: Failure, in some instances, to accurately track the submission type and number of days required to adjudicate claims.

Utilization Review: One (1) area of concern was identified during the review of the Company's utilization review procedures.

Issue K1: Failure, in some instances, to ensure that the physician who evaluated 1st level reviews was not also involved in the original benefit denial.

MARKET CONDUCT EXAMINATION REPORT

FACTUAL FINDINGS

COLORADO CHOICE HEALTH PLANS D.B.A SAN LUIS VALLEY HMO

POLICY FORMS
FINDINGS

Issue E1: Failure, in some instances, to qualify dependent eligibility in accordance with the requirements of Colorado insurance law. *(This was prior issue E1 in the findings of the market conduct examination report dated September 6, 2002.)*

Section 10-16-102, C.R.S., Definitions, states:

> (14) *"Dependent" means a spouse, an unmarried child under nineteen years of age, an unmarried child who is a full-time student under twenty-four years of age and who is financially dependent upon the parent,* and an unmarried child of any age who is medically certified as disabled and dependent upon the parent.

Section 10-16-104, C.R.S., Mandatory coverage provisions, states in part:

> (6) Dependent Children.
>
> (b) No entity described in paragraph (a) of this subsection (6) shall refuse to provide coverage for a dependent child under the health plan of the child's parent for the sole reason that the child:
>
> (II) *Does not live in the insurer's service area*, notwithstanding any other provision of law restricting enrollment to persons who reside in an insurer's service area; or . . . [Emphasis added.]

Section 10-16-104.3, C.R.S., Dependent health coverage for persons under twenty-five years of age, states in part:

> (1) *All individual and group sickness and accident insurance policies providing coverage within the state by an entity subject to the provisions of* part 2 of this article and all group health service contracts issued by an entity subject to the provisions of *part 3 or 4 of this article that offer dependent coverage shall offer to the parent, for an additional premium if applicable, by rider or supplemental policy provision, the same dependent coverage for an unmarried child who is under twenty-five years of age, and is not a dependent as defined by section 10-16-102 if such child:*
>
> *(a) Has the same legal residence as the parent; or*
>
> *(b) Is financially dependent upon the parent.* [Emphases added.]

It appears that in some instances, the Company's forms are not in compliance with Colorado insurance law in that they contain eligibility requirements for dependents that are more restrictive than allowed under Colorado insurance law. The following provisions appear to conflict with Colorado law in that they:

- Require a dependent child to live within the service area;
- Require a dependent child to be chiefly dependent upon the parent for financial support;

- Limit coverage for dependents under twenty-five years of age that are not otherwise included in the definition of dependent under § 10-16-102, C.R.S., to the end of the month that they attain age twenty-four instead of twenty-five;
- Require a dependent child to be financially dependent, claimed, and eligible as a dependent on the subscriber's federal income tax return;
- Require a dependent child who is medically certified as disabled to be claimed and eligible as a dependent on the subscriber's federal income tax return;

Colorado law does not require a dependent child to live within the service area of the HMO, and only requires that an unmarried child under the age of twenty-four (24) who is a full time student be financially dependent. There is no requirement that a dependent be "chiefly" dependent on the parent. In addition, a dependent child under twenty-five years of age who is eligible for coverage upon payment of an extra premium, would be eligible through the end of the month the person attains age 25 instead of 24. Finally, there is no requirement for a dependent child under age nineteen to be financially dependent, and neither a dependent child under age nineteen, nor a dependent certified as medically disabled is required to be claimed, or eligible to be claimed as a dependent on the subscriber's federal income tax return.

The Company's small group and individual direct pay medical and hospital service agreement forms state in part:

> Article 2. - Definitions
>
> 2.6 "Child" means: an unmarried Child under age nineteen (19) who lives within the Service Area or an unmarried Child under the age of 24 who is a full-time student, who is chiefly dependent upon the Subscriber or Subscriber's Spouse for financial support, …

The Company's Group Application form states in part:

> ELIGIBILITY PROVISIONS
>
> Dependents:
>
> Dependent children of the subscriber are covered through the last day of the month in which they attain the age of 19: …In addition, an unmarried Child who is under twenty-five (25) years of age and has the same legal residence as the parent or is financially dependent upon the parent may be covered through the end of month they attain age 24 …
>
> Requirements: 1) Child is financially dependent, claimed, and eligible as a dependent on the subscriber's federal income tax return for the date(s) covered services are provided under this contract. …3) Child is disabled and financially dependent, claimed and eligible as a dependent on the subscriber's federal income tax return

Form:	Date:
SLVSGMHSA	12/2005
SLVDPMHSA	12-2005
Colorado Choice Health Plans Group Application (No form number)	No Date

Recommendation No. 1:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §§ 10-16-102, 10-16-104, and 10-16-104.3, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised all applicable forms to correctly outline the requirements for dependent eligibility.

In the market conduct examination for the period January 1, 2001 to December 31, 2001, the Company was cited for failure to qualify dependent status in compliance with the requirements of Colorado insurance law. The violation resulted in Recommendation #1 of Final Agency Order O-03-151, that the Company "shall provide documentation to the Division that it has revised all forms to apply the correct criteria for defining an eligible dependent". Failure to comply with the previous order of the commissioner may constitute a violation of § 10-1-205, C.R.S.

Issue E2: Failure, in some instances, to limit Members' liability to the stated copayments. *(This was prior issue E2 in the findings of the market conduct examination report dated September 6, 2002.)*

Regulation 4-7-2, Health Maintenance Organization Benefit Contracts and Services in Colorado, promulgated and adopted by the Commissioner of Insurance under the authority of Section 10-16-109, C.R.S., states:

> Section 4. Definitions
>
> A. "Copayment" means the *predetermined amount*, whether stated as a percentage or a fixed dollar, *an enrollee must pay to receive a specific service or benefit.*
>
> Section 7. Services
>
> A. Out-of-Area Services and Benefits
>
> 1. *Out-of-area services shall be subject to copayment or deductible requirements set forth in Subsection C of Section 8 of this regulation.*
>
> Section 8 Other Requirements
>
> C. Copayments or Deductibles
>
> 1. An HMO may require copayments and/or deductibles of enrollees as a condition for the receipt of specific health care services. *Copayments* and deductibles for basic health care services *shall be shown in the contract and/or evidence of coverage or an addendum thereof as a percentage or as a specified dollar amount.* [Emphases added.]

It appears that in some instances, the Company's forms are not in compliance with Colorado insurance law in that they limit coverage for emergency medical care received outside the Company's service area to reasonable and customary charges less the applicable copayments. This limitation may fail to hold members harmless against charges in excess of their contractual out-of-pocket expenses by not limiting their liability to the stated copayment amounts, since they would be responsible for payment of any amounts that exceeded the reasonable and customary charges in addition to the applicable copayments.

The Company's Small Group Benefit Schedule states in part:

> ARTICLE 6. MEDICAL CARE OUTSIDE THE SERVICE AREA
>
> 6.3 Emergency Medical Care. Covered worldwide. Emergency benefits out of the area are limited to reasonable and customary charges, less the applicable copayments. …

The Company's Direct Pay (Individual) Benefit Schedule states in part:

ARTICLE 5. MEDICAL CARE OUTSIDE THE SERVICE AREA

5.3 Emergency Medical Care. Covered worldwide. Emergency benefits out of the area are limited to reasonable and customary charges, less the applicable copayments. …

Form:	Date:
SLVSGBS	12/2005
SLVDPBS	12-2005

Recommendation No. 2:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Regulation 4-7-2. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised all applicable forms to ensure that Members' liability for covered services is limited to the copayments stated in their plans.

In the market conduct examination for the period January 1, 2001 to December 31, 2001, the Company was cited for failure to qualify dependent status in compliance with the requirements of Colorado insurance law. The violation resulted in Recommendation #1 of Final Agency Order O-03-151, that the Company "shall provide documentation to the Division that it has revised all forms to ensure that members' liability for services covered by the health maintenance organization is limited to the stated copayments in compliance with Colorado insurance law". Failure to comply with the previous order of the commissioner may constitute a violation of § 10-1-205, C.R.S.

Issue E3: Failure of the Company's individual health plan forms, in some instances, to provide coverage for complications of pregnancy and childbirth in the same manner as any other sickness, injury, disease or condition is covered.

Section 10-16-104, C.R.S., Mandatory coverage provisions, states in part:

(2) Complications of pregnancy and childbirth.

(a) Any sickness and accident insurance policy providing indemnity for disability due to sickness issued by an entity subject to the provisions of part 2 of this article and *any individual or group service or indemnity contract issued by an entity subject to part 3 of this article shall provide coverage for a sickness or disease which is a complication of pregnancy or childbirth in the same manner as any other similar sickness or disease is otherwise covered under the policy or contract.* Any sickness and accident insurance policy providing indemnity for disability due to accident shall provide coverage for an accident which occurs during the course of pregnancy or childbirth in the same manner as any other similar accident is covered under the policy. [Emphasis added.]

Section 10-16-118, C.R.S., Limitations on preexisting condition limitations, states in part:

(1) *A health coverage plan that covers residents of this state:*

(a)(II) *If it is an individual health benefit plan,* or a group health coverage plan to which subparagraph (I) of this paragraph (a) does not apply, *shall not deny, exclude, or limit benefits for a covered individual because of a preexisting condition for losses incurred more than twelve months following the effective date of coverage and may not define a preexisting condition more restrictively than an injury, sickness, or pregnancy for which a person incurred charges, received medical treatment, consulted a health care professional, or took prescription drugs within twelve months.*

(b) *Shall waive any* affiliation period or *time period applicable to a preexisting condition exclusion or limitation period for the period of time an individual was previously covered by creditable coverage if such creditable coverage was continuous to a date not more than ninety days prior to the effective date of the new coverage.* The period of continuous coverage shall not include any waiting period for the effective date of the new coverage. This paragraph (b) shall not preclude application of any waiting period applicable to all new enrollees under the plan. The method of crediting and certifying coverage shall be determined by the commissioner by rule. [Emphases added.]

It appears that in some instances, the Company's individual (direct pay) health plan forms are not in compliance with Colorado insurance law in that they impose a twenty-four (24) month waiting period and a $2,000 maximum benefit per delivery for maternity benefits. In addition, it appears that all maternity related treatment, including complications of pregnancy and childbirth, are subject to these overall limitations for maternity benefits since "Prenatal and Postnatal Care", "Hospital Room and Board", "Complications", etc., are all listed as subsections of the "Maternity Benefits" section in the benefit summary.

Colorado insurance law requires individual health benefit plans to provide coverage for a condition which is a complication of pregnancy or childbirth in the same manner as any other sickness or illness is covered under the plan. Therefore, a carrier cannot add additional restrictions such as waiting periods or maximum benefit limitations to complications of pregnancy or childbirth that are not applicable to other conditions covered by the plan.

The Company's Direct Pay (individual) Benefit Schedule states in part:

> Article 6. MATERNITY BENEFITS
>
> Medically Necessary maternity care is covered as follows, subject to a 24 month waiting period before eligible for coverage and a maximum benefit of $2,000 for professional services and facility charges per delivery:
>
> > 6.1 Availability Maternity benefits are available for direct pay members, subject to a 24 month waiting period and a maximum benefit of $2,000 for professional services and facility charges per delivery.
> >
> > 6.2 Prenatal and Postnatal Care Prenatal and postnatal care are covered, subject to a 24 month waiting period and a maximum benefit of $2,000 for professional services and facility charges per delivery.
> >
> > 6.3 Hospital Room and Board Hospital room and board is covered as for any covered illness or injury. Certified length of stay for routine vaginal delivery and caesarean section is covered as Medically Necessary. Coverage shall be in compliance with C.R.S. 10-160104(1)(b)(I) (sic) which states that coverage for a hospital stay for a newborn following a normal vaginal delivery shall no (sic) be limited to less than forty-eight hours. …

6.4 Delivery and Nursing Care Delivery services and facilities and nursing care are covered in a Hospital only.

6.7 Complications Medically Necessary care for complications including miscarriages, caesarian sections, ectopic pregnancies, is covered.

The Company's Colorado Health Plan Description Form which the Company indicated is used as the copay schedule for the most frequently sold individual plan (COMP 5000 DP), states in part the following:

10. MATERNITY [7] a) Prenatal care b) Delivery & inpatient well baby care[5]	Subject to a 24 month waiting period and a $2,000 maximum benefit on professional services and facility charges per delivery a) and b) Coinsurance as described in #5 above.

Form:	Date:
SLVDPBS	12-2005
DOI COMP 5000 DP	12-2005

Recommendation No. 3:

Within thirty (30) days the Company should provide documentation demonstrating why it should not be considered in violation of §§ 10-16-104, and 10-16-118, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised all applicable forms to ensure that coverage for maternity care, including complications of pregnancy, is provided in accordance with the requirements of Colorado insurance law.

Issue E4: Failure, in some instances, to provide dependent coverage beyond thirty-one (31) days if notification of the dependent's birth or placement for adoption is not received within thirty-one (31) days.

Section 10-16-104, C.R.S., Mandatory coverage provisions, states in part:

(1) Newborn children.

(a) All group and individual sickness and accident polices and all service or indemnity contracts issued by any entity subject to part 3 or 4 of this article shall provide coverage for a dependent newborn child of the insured or subscriber from the moment of birth.

(d) If payment of a specific premium is required to provide coverage for a child, the policy may require that notification of birth of the newborn child and payment of the required premium must be furnished to the insurer or other entity within thirty-one days after the date of birth in order to have the coverage continue beyond such thirty-one-day period. [Emphasis added.]

It appears that in some instances, the Company's forms are not in compliance with Colorado insurance law in that they require notification of the birth of a newborn or placement of a dependent for adoption within thirty-one (31) days, in order to continue coverage of the dependent beyond the first thirty-one (31) days following birth or placement for adoption. The Company's forms do not allow for situations where the newborn is already covered under a member's health plan (i.e., where the member already has family coverage) and no additional premium is required.

The Company's Small Group and Individual (Direct Pay) Benefit Schedules state in part:

ARTICLE 2. PHYSICIAN SERVICES

2.1 Preventive and Health Maintenance Services

A. Newborn and Pediatric Care – Except as provided in Article 5, routine newborn care and treatment of illness or injury of the newborn are covered for the first 31 days from the moment of birth. *The child must be enrolled within 31 days after the date of birth for such coverage to continue beyond the first 31 days.* …

The Company's Small Group and Individual (Direct Pay) Medical and Hospital Service Agreements state in part:

ARTICLE 4.-ENROLLMENT AND EFFECTIVE DATE

4.5 [4.4] Subscribers dependent newborn children and children placed for adoption are automatically covered for 31 days regardless of enrollment in the plan. *To obtain Dependent Coverage beyond 31 days a subscriber must enroll the*

> *newborn child with PLAN within 31 days after the birth or placement for adoption by furnishing notification of the birth or the child's placement for adoption to PLAN. Notification to PLAN shall be by submission to PLAN of a completed change form.* … [Emphases added.]

Form:	Date:
SLVSGBS	12/2005
SLVSGMHSA	12/2005
SLVDPBS	12-2005
SLVDPMHSA	12-2005

Recommendation No. 4:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised all applicable forms to reflect that notification of the birth or placement of a dependent for adoption may only be required if the addition of such dependent would result in the requirement for payment of a specific premium to continue coverage beyond the first thirty-one (31) days.

Issue E5: Failure, in some instances, to reflect coverage for transplants in accordance with Colorado insurance law.

Section 10-3-1104, C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states in part:

(1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

(f) Unfair discrimination:

(II) *Making or permitting any unfair discrimination between individuals of the same class* or between neighborhoods within a municipality *and of essentially the same hazard* in the amount of premium, policy fees, or rates charged for any policy or contract of insurance, or *in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever;* [Emphasis added.]

Colorado Insurance Regulation 4-6-5, Concerning The Basic and Standard Health Benefit Plans, promulgated pursuant to §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states in part:

BASIC AND STANDARD HEALTH BENEFIT PLAN
POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance
January 1, 2006

1. The basic health benefit plan as defined by the Commissioner pursuant to §10-16-105(7.2)(b), C.R.S., for an indemnity, preferred provider, and health maintenance organization (HMO) plan *shall include the specific benefits and coverages outlined in one of the attached tables labeled "Basic Limited Mandate Health Benefit Plan", "Basic HSA Health Benefit Plan", or "Basic HSA Limited Mandate Health Benefit Plan".*

2. The standard health benefit plan for an indemnity, preferred provider, and HMO plan *shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan."*

Benefit Grids:

JANUARY 1, 2006 COLORADO BASIC {LIMITED MANDATE, HSA, & HSA LIMITED MANDATE} HEALTH BENEFIT PLANS:
INDEMNITY, PREFERRED PROVIDER, AND HMO

PART B: SUMMARY OF BENEFITS

	BASIC INDEMNITY PLAN	**BASIC PREFERRED PROVIDER PLAN**		**BASIC HMO PLAN**
		IN-NETWORK	**OUT-OF-NETWORK** [1a]	**IN-NETWORK ONLY (out-of-network care is not covered except as noted)**
24. ORGAN TRANS-PLANTS[18]	Covered transplants include: liver, heart, heart/lung, *lung*, cornea, kidney, kidney/pancreas, and bone marrow for Hodgkin's, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer, and Wiskott-Aldrich syndrome only. Peripheral stem cell support is a covered benefit for the same conditions as listed above for bone marrow transplants.			

JANUARY 1, 2006 COLORADO STANDARD HEALTH BENEFIT PLANS: INDEMNITY, PREFERRED PROVIDER, AND HMO

PART B: SUMMARY OF BENEFITS

	STANDARD INDEMNITY PLAN	**STANDARD PREFERRED PROVIDER PLAN**		**STANDARD HMO PLAN**
24. ORGAN TRANS-PLANTS[22]		**IN-NETWORK**	**OUT-OF-NETWORK** [1a]	**IN-NETWORK ONLY (out-of-network care is not covered except as noted)**
	Covered transplants include: liver, heart, heart/lung, *lung*, cornea, kidney, kidney/pancreas, and bone marrow for Hodgkin's, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer, and Wiskott-Aldrich syndrome only. Peripheral stem cell support is a covered benefit for the same conditions as listed above for bone marrow transplants.			

[Emphases added.]

It appears that in some instances, the Company's forms are not in compliance with Colorado insurance law in that they fail to include all required transplant procedures, and/or they exclude coverage for transplants that would otherwise be covered when the transplant is necessitated by disease primarily attributable to a member's smoking or use of alcohol. Specifically:

- The Company's Basic and Standard Benefit Plans Benefit Schedule does not include coverage for lung transplants. Although the combination "heart/lung" transplant is listed as a covered benefit, the required coverage for a stand alone lung transplant is not included.

- The Benefit Schedule states in the General Terms Under Which Benefits Are Provided section: "A service or supply not expressly included in the Benefit Schedule is not a covered benefit, even if it is not specifically listed as an exclusion in Article 8."

- The Company's Small Employer Group Plans Benefit Schedule which is used for non-Basic and Standard small group plans includes coverage for all transplants that are required under the Basic and Standard health benefit plans, but excludes coverage for "heart, lung, or heart/lung" transplants when such transplants are necessitated by disease primarily attributable to a member's smoking, and also excludes coverage for "liver" transplants when such transplants are necessitated by disease primarily attributable to a member's use of alcohol.

Excluding coverage for transplants that would otherwise be covered when the transplant is necessitated by disease primarily attributable to a member's smoking or use of alcohol, appears to unfairly discriminate between individuals of the same class, and of essentially the same hazard in the benefits, terms, and/or conditions of the health plans.

The examiner also noted that the Company's "Colorado Health Plan Description Forms", used as the co-payment schedules for the Company's Basic and Standard health benefit plans, do contain the correct description of the mandated transplant coverage. However, these forms also state: "**Important Note**: This form is not a contract, it is only a summary. The contents of this form are subject to the provisions of the policy, which contain all terms, covenants and conditions of coverage." This language appears to restrict benefits for transplants to those listed in the Benefit Schedule and is misleading and confusing to the Members in regard to their transplant benefits.

The Company's Basic and Standard Benefit Plans Benefit Schedule states in part the following:

ARTICLE VII OTHER SERVICES

7.10 Organ and Tissue Transplants. Covered transplants include: liver, heart, heart/lung, cornea, kidney, kidney/pancreas, and bone marrow for Hodgkin's, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer, and Wiskott-Aldrich syndrome only. Peripheral stem cell support is a covered benefit for the same conditions as listed above for bone marrow transplants. Transplants will be covered only if they are medically necessary and the facility meets clinical standards for the procedure.

The Company's Small Employer Group Plans Benefit Schedule states in part the following:

ARTICLE 7. OTHER SERVICES

7.9 Organ and Tissue Transplants. Covered transplants include: heart; lung; heart/lung, *except when necessitated by disease primarily attributable to a member's smoking*; liver, *except when necessitated by disease primarily attributable to a member's use of alcohol*; kidney; pancreas for uremic insulin-dependent diabetics concurrently receiving a kidney transplant; cornea; bone marrow for treatment of neuroblastoma and Hodgkins or non-Hodgkins lymphoma; autologous or allogeneic bone marrow transplants and stem cell rescue

or hematopoitic support only for malignant tumors when necessary to support high dose chemotherapy, (and in that event the high dose chemotherapy is covered); and autologous or allogeneic bone marrow transplants and/or stem cell rescue only for aplastic anemia, leukemia, hereditary severe combined immunodeficiency disease, Wiskott-Aldrich syndrome, and High Risk Stage II and III breast cancer. [Emphases added.]

Form	Form Number
SLVSBBS	12-2005
SLVSGBS	12-2005

Recommendation No. 5:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-3-1104, C.R.S. and Colorado Insurance Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised all applicable forms to correctly reflect the coverage mandated for transplants as required by Colorado insurance law.

Issue E6: Failure of the Company's forms, in some instances, to include coverage for basic health care services.

Section 10-16-102, C.R.S., Definitions, states in part:

> (5) "Basic health care services" means health care services that an enrolled population of a health maintenance organization organized pursuant to the provisions of part 4 of this article might reasonably require in order to maintain good health, including as a minimum, emergency care, inpatient and outpatient hospital services, physician services, outpatient medical services, and laboratory and X-ray services.

Section 10-16-402, C.R.S., Issuance of certificate of authority – denial, states in part:

> (2) The commissioner shall issue or deny a certificate of authority to any person filing an application pursuant to section 10-16-401 within thirty days of receipt of the certification from the executive director. Issuance of a certificate of authority shall be granted upon payment of the application fee prescribed in section 10-16-110 (2) if the commissioner is satisfied that the following conditions are met:
>
> (c)(I) *The health maintenance organization will effectively provide or arrange for the provision of basic health care services,* through insurance or otherwise, except to the extent of reasonable requirements for copayments, deductibles, and payments for out-of-network services received pursuant to section 10-16-704 (2). [Emphasis added.]

It appears that in some instances, the Company's forms are not in compliance with Colorado insurance law in that they exclude:

- All services or supplies rendered for any illness, injury, or condition to the extent that benefits are available to the Member as an insured under the terms of any insurance (except group or individual health insurance) policy that is in force or would be available to the Member under a policy that is required to be in force under applicable law, but for the fact that the Member does not carry such policy contrary to such law.

- Expenses for any condition or complication directly caused by any non-covered procedure, treatment, service, drug, device, product or supply, and all procedures relating to complications from elective, non-covered services.

- Blood and blood plasma.

Although an HMO may include coordination of benefits and/or subrogation provisions in its coverage forms, it cannot totally exclude coverage for basic health care services or supplies that would otherwise be covered solely on the basis that those services or supplies may be also be eligible for coverage under another insurance policy (even where such coverage is required to be in force under applicable law), except for workers compensation policies.

In addition, although an HMO may exclude coverage for certain procedures, treatments, services, etc., it must still provide coverage for basic health care services that may be required for complications or conditions that would otherwise be covered regardless of whether they were directly caused by a non-covered procedure, treatment, service, etc.

Furthermore, blood and blood plasma are considered "basic health care services" and therefore must be covered by an HMO.

The Company's Small Employer Group Plans Benefit Schedule states in part:

> ARTICLE 8. EXCLUSIONS AND LIMITATIONS
>
> All the following services, accommodations, care, equipment, medications or supplies are expressly excluded from coverage:
>
> 8.3 *All services or supplies rendered for any illness, injury, or condition to the extent that benefits are either (i) available to the Member as an insured under the terms of any insurance* (except group or individual health insurance) *policy that is in force or (ii) would be available to the Member under a policy that is required to be in force under applicable law, but for the fact that the Member does not carry such policy contrary to such law.*
>
> 8.6. *Expenses for any condition or complication directly caused by any non-covered procedure, treatment, service, drug, device, product or supply are excluded from coverage.*
>
> 8.33 …Immunization agents, biological sera, antigen, *blood and blood plasma.* …

The Company's Basic and Standard Benefit Plans Benefit Schedule states in part:

> ARTICLE VIII. EXCLUSIONS AND LIMITATIONS
>
> All the following services, accommodations, care, equipment, medications or supplies are expressly excluded from coverage:
>
> 8.3 *All services or supplies rendered for any illness, injury, or condition to the extent that benefits are either (i) available to the Member as an insured under the terms of any insurance* (except group or individual health insurance) *policy that is in force including without limitation homeowners or renters, commercial premises or comprehensive general liability insurance coverage*.
>
> 8.6. *Expenses for any condition or complication directly caused by any non-covered procedure, treatment, service, drug, device, product or supply are excluded from coverage.*

8.35 …Immunization agents, biological sera, antigen, *blood and blood plasma.*

8.43 *All procedures relating to complications from elective, non-covered services.*
[Emphases added.]

(The examiner notes that "whole blood, blood plasma and other blood products" are listed as covered items under Hospital Room and Board benefits in both the Small Group and Basic and Standard Benefit Plans Benefit Schedules. However, the fact that blood and blood plasma are also listed as exclusions is misleading and confusing to Members regarding this coverage.)

Form:	Date:
SLVSGBS	12/2005
SLVSBBS	12/2005

Recommendation No. 6:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-402, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised all applicable forms to provide coverage for basic health care services as required by Colorado insurance law.

Issue E7: Failure of the Company's Basic and Standard health benefit plan forms to provide mandated coverage for dental care needed as a result of an accident.

Colorado Insurance Regulation 4-6-5, Concerning The Basic and Standard Health Benefit Plans, promulgated pursuant to §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states in part:

BASIC AND STANDARD HEALTH BENEFIT PLAN
POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance
January 1, 2006

1. The basic health benefit plan as defined by the Commissioner pursuant to §10-16-105(7.2)(b), C.R.S., for an indemnity, preferred provider, and health maintenance organization (HMO) plan *shall include the specific benefits and coverages outlined in one of the attached tables labeled "Basic Limited Mandate Health Benefit Plan", "Basic HSA Health Benefit Plan", or "Basic HSA Limited Mandate Health Benefit Plan".*

2. The standard health benefit plan for an indemnity, preferred provider, and HMO plan *shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan."*

Benefit Grids:

JANUARY 1, 2006 COLORADO BASIC {LIMITED MANDATE, HSA, & HSA LIMITED MANDATE} HEALTH BENEFIT PLANS:
INDEMNITY, PREFERRED PROVIDER, AND HMO

PART B: SUMMARY OF BENEFITS

	BASIC INDEMNITY PLAN	**BASIC PREFERRED PROVIDER PLAN**		**BASIC HMO PLAN**
		IN-NETWORK	**OUT-OF-NETWORK** [1a]	**IN-NETWORK ONLY (out-of-network care is not covered except as noted)**
28. DENTAL CARE	*For all plans, not covered except for dental care needed as a result of an accident.*			

JANUARY 1, 2006 COLORADO STANDARD HEALTH BENEFIT PLANS: INDEMNITY, PREFERRED PROVIDER, AND HMO

PART B: SUMMARY OF BENEFITS

	STANDARD INDEMNITY PLAN	**STANDARD PREFERRED PROVIDER PLAN**		**STANDARD HMO PLAN**
28. DENTAL CARE		**IN-NETWORK**	**OUT-OF-NETWORK** [1a]	**IN-NETWORK ONLY (out-of-network care is not covered except as noted)**
	For all plans, not covered except for dental care needed as a result of an accident.			

[Emphases added.]

It appears that the Company's Basic and Standard health benefit plan forms are not in compliance with Colorado insurance law in that they limit coverage for dental care to less than what is required by Colorado insurance law. The forms limit coverage to oral surgery services provided upon written referral for treatment for accidental injury to sound natural teeth, further limited to treatment of traumatized teeth and surrounding tissue provided within twenty-four (24) hours after injury.

Colorado insurance law requires coverage for dental care needed as a result of an accident under the Basic and Standard health benefit plans. There are no provisions in the law for further limiting coverage to only oral surgery services provided upon written referral, or to limiting coverage for needed treatment to twenty-four (24) hours after injury.

The Company's Basic and Standard Benefit Plans Benefit Schedule states in part the following:

ARTICLE VII OTHER SERVICES

7.12 Oral Surgery/Dental Anesthesia Services. *The following oral surgery services are covered upon Written Referral:* …(v) *treatment for accidental injury to sound natural teeth, limited to treatment of traumatized teeth and surrounding tissue provided within 24 hours after injury.* No other oral surgery services are covered with the exception of Colorado mandatory coverage which provides for hospitalization and general anesthesia services for dental procedures for dependent children …

ARTICLE VIII. EXCLUSIONS AND LIMITATIONS

All the following services, accommodations, care, equipment, medications or supplies are expressly excluded from coverage:

8.45 *Except as otherwise provided herein, dental benefits are optional and are covered only under a Dental Benefit Plan.* [Emphases added.]

Form	Form Number
SLVSBBS	12-2005

Recommendation No. 7:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its Basic and Standard health benefit plan forms to provide coverage for dental care needed as a result of an accident as required by Colorado insurance law.

Issue E8: Failure, in some instances, to provide continuation coverage if an individual is eligible for Medicare or Medicaid.

Section 10-16-108, Conversion and continuation privileges, states, in part:

(2) Group contracts of nonprofit hospital, medical-surgical, and health service corporations and group service contracts of health maintenance organizations.

(a) *Every group contract or group service contract providing hospital services, medical-surgical services, or other health services for subscribers or enrollees and their dependents issued by* a nonprofit hospital, medical-surgical, and health service corporation or *a health maintenance organization* operating with a certificate of authority pursuant to part 3 or 4 of this article *shall contain a provision which permits every covered employee or enrollee of an employed group whose employment is terminated, if the contract remains in force for active employees of the employer, to elect to continue the coverage for such employee and the employee's dependents. Such provision shall conform to the requirements, where applicable, of paragraphs (b),* (c), and (d) *of this subsection (2).*

(b)(III) The employer shall not be required to offer continuation of coverage of any person if such person is *covered* by medicare, Title XVIII of the federal "Social Security Act", or medicaid, Title XIX of the federal "Social Security Act". [Emphases added.]

It appears that in some instances, the Company is not in compliance with Colorado insurance law in that its contract forms provide that continuation coverage will be available only if on the date the Member's or Dependent's coverage would otherwise cease, the person seeking continuation does not qualify for Medicare or Medicaid.

Colorado insurance law states that an offer of continuation of coverage need not be extended if the Member is already covered by Medicare or Medicaid when they become eligible for continuation of coverage. A carrier is not allowed to deny coverage solely because a Member is eligible for Medicare or Medicaid at the time they become eligible for continuation coverage.

The Company's contract forms state, in part:

11.2(a) The Colorado Continuation of Coverage will be available only if, on the date the Member's or Dependent's coverage would otherwise cease:

(iii) the person seeking continuation does not qualify for Medicare or Medicaid;

Form	Date
SLVSGMHSA	12/2005

Recommendation No. 8:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-108, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised all applicable forms to provide continuation coverage to individuals who may be eligible, but are not covered by Medicare or Medicaid, as required by Colorado insurance law.

CLAIMS
FINDINGS

Issue J1: Failure, in some instances, to allow the required thirty (30) calendar days for necessary additional information to be received before denying an unclean claim.

Section 10-16-106.5, C.R.S., Prompt payment of claims-legislative declaration, states in part:

> (2) As used in this section, "clean claim" means a claim for payment of health care expenses that is submitted to a carrier on the uniform claim form adopted pursuant to section 10-16-106.3 with all required fields completed with correct and complete information, including all required documents. A claim requiring additional information shall not be considered a clean claim and shall be paid, denied or settled as set forth in paragraph (b) of subsection (4) of this section. "Clean Claim" does not include a claim for payment of expenses incurred during a period of time for which premiums are delinquent, except to the extent otherwise required by law.
>
> (4) (b) If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim. The person receiving a request for such additional information shall submit all additional information requested by the carrier within thirty calendar days after receipt of such request. *Notwithstanding any provision of an indemnity policy to the contrary, the carrier may deny a claim if a provider receives a request for additional information and fails to timely submit additional information requested under this paragraph (b), subject to resubmittal of the claim or the appeals process.* If such person has provided all such additional information necessary to resolve the claim, the claim shall be paid, denied, or settled by the carrier within the applicable time period set forth in paragraph (c) of this subsection (4). [Emphasis added.]

DENIED CLAIMS

Population	Sample Size	Number of Exceptions	Percentage to Sample
4,006	50	6	12%

The examiner reviewed a random sample of fifty (50) claims from a summarized population of 4,006 claims that had been denied by the Company during the examination period. It appears the Company is not in compliance with Colorado insurance law in that six (6) of the fifty (50) claims reviewed were denied at the same time additional information was requested, without waiting the required thirty (30) calendar days for the additional information to be submitted. Five (5) claims involved requests for emergency department records, and one (1) claim involved a request for a Medicare explanation of benefits statement.

Colorado's prompt claim payment law allows a Company to deny claims needing additional information only after notifying the claimant of the information needed and allowing thirty (30) calendar days for the information to be received.

Recommendation No. 9:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-106.5, C.R.S. In the event that the Company is unable to show such proof, it should provide evidence to the Division that it has revised its procedures to ensure that the required thirty (30) calendar days are allowed for submission of necessary additional information before claims are denied, as required by Colorado insurance law.

Issue J2: Failure, in some instances, to accurately track the submission type and number of days required to adjudicate claims.

Section 10-16-106.5, C.R.S., Prompt payment of claims-legislative declaration, states in part:

(2.7)(a) *A* policyholder, insured, or *provider may submit a claim*:

(I) By United States mail, first class, or by overnight delivery service;

(II) *Electronically*;

(III) By facsimile (fax); or

(IV) By hand delivery.

(b)(II) *If the claim is submitted electronically, the claim is presumed to have been received on the date of the electronic verification of receipt by the carrier or the carrier's clearinghouse.* The carrier or carrier's clearinghouse shall provide a confirmation within one business day after submission by a provider.

(4)(a) Clean claims shall be paid, denied, or settled *within thirty calendar days after receipt by the carrier if submitted electronically* and within forty-five calendar days after receipt by the carrier if submitted by any other means. [Emphases added.]

PAID & DENIED CLAIMS

Population	Sample Size	Number of Exceptions	Percentage to Sample
41,367	150	9	6%

During the review of both paid and denied claims, the examiner reviewed a total of 150 claims. Of these, nine (9) claims appeared to have been submitted directly to Sloans Lake Preferred Health Network (Sloans) electronically, but were considered as paper claims when logged into the Company's claims system.

According to information provided by the Company, Sloans is contracted with SLVHMO as a secondary network that is used primarily for services that are provided outside SLVHMO's own network. In most cases, the providers who are contracted with Sloans submit their claims directly to Sloans where they are re-priced to the contracted amount before being sent on to SLVHMO for payment.

It appears that the Company is not in compliance with Colorado insurance law in that all nine (9) claims submitted to Sloans appear to have been submitted electronically, and were subsequently converted to paper claims during the re-pricing process before being submitted to SLVHMO for payment. Since Sloans is contracted with SLVHMO as a supplemental managed care network, and Sloans acts as a "clearinghouse" for claims submitted by Sloans providers, claims are considered received by SLVHMO

when received by Sloans. Since these claims were submitted electronically to Sloans, they should be considered electronic claims for the purpose of the time period allowed for payment by SLVHMO.

For claims submitted directly to Sloans and subsequently forwarded to SLVHMO for payment, SLVHMO should record the date the claim was received by Sloans as its received date; for this sample, the received date for each of the nine (9) claims was logged as the date SLVHMO received the claim from Sloans. Since the nine (9) claims reviewed represented all the claims received and re-priced by Sloans in the two claims samples, this appears to be a general business practice by the Company.

Although all nine (9) claims were adjudicated within the required thirty (30) days, even after consideration of the date the claim was originally received by Sloans, recording an incorrect received date could result in a requirement for payment of interest even though the processing time after the claim was received from Sloans was less than thirty (30) days. Regardless of whether or not claims are adjudicated within the required time period, recording an incorrect received date does not accurately reflect the amount of time required to adjudicate those claims.

Recommendation No. 10:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-106.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has reviewed and modified its procedures to ensure that the claim submission type (electronic vs. paper) is accurately recorded, and that the received date recorded in the claims system is the date the claim was first received by the Company or any intermediary.

UTILIZATION REVIEW FINDINGS

Issue K1: Failure, in some instances, to ensure that the physician who evaluated 1st level reviews was not also involved in the original benefit denial.

Colorado Insurance Regulation 4-2-17, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated pursuant to Sections 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b), and 10-16-109, C.R.S., states in part:

Section 10 First Level Review

E. Conduct of first level reviews.

(1) First level reviews shall be evaluated by a physician who shall consult with a clinical peers or peers, unless the reviewing physician is a clinical peer. *The physician and clinical peer(s) shall not have been involved in the initial adverse determination.* However, a person that was previously involved with the denial may answer questions. [Emphasis added.]

FIRST LEVEL REVIEWS

Population	Sample Size	Number of Exceptions	Percentage to Sample
20	20	8	40%

The examiner reviewed the entire population of twenty (20) 1st level review appeal files received by the Company during the examination period.

It appears that in some instances, the Company was not in compliance with Colorado insurance law in that in eight (8) of the twenty (20) files reviewed, the documentation indicates that the physician who evaluated the 1st level review was also involved in the original benefit denial.

Recommendation No. 11:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has reviewed and modified its procedures to ensure that the physician who makes the initial adverse determination will not be permitted to evaluate 1st level reviews.

SUMMARY OF ISSUES AND RECOMMENDATIONS

Jeffory A. Olson, CIE, FLMI, AIRC, ALHC
Senior Market Conduct Examiner

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Conducted this market conduct examination and prepared this report.